2017 SHOP SADP Plans

`	57601NH0390004		87701NH0110001	57601NH0390003		87701NH0120001
Insurance Company	**Anthem**		**Delta Dental**	**Anthem**		**Delta Dental**
Plan Name	**Anthem Dental Family Enhanced**		Delta Dental PPO Family High Plan	**Anthem Dental Family**		Delta Dental PPO Family Low Plan
Metal Level	**High**		**High**	**Low**		**Low**
Plan Documents & Links	Dental Complete Plan Brochure		Delta Dental PPO Plan Brochure	Dental Complete Plan Brochure		Delta Dental PPO Plan Brochure
Network Coverage	In Network	Out of Network	In Network and Out of Network	In Network	Out of Network	In Network and Out of Network
Deductible-Individual/Family	$25 per person | per group not applicable	$25 per person | per group not applicable	$50 per person | per group not applicable	$50 per person | per group not applicable	$50 per person | per group not applicable	$150 per person | per group not applicable
Max Out of Pocket-Individual/Family	$350 per person | $700 per group	per person not applicable | per group not applicable	$350 per person | $700 per group	$350 per person | $700 per group	per person not applicable | per group not applicable	$350 per person | $700 per group
Dental Check-Up for Children	No Charge after deductible	20% Coinsurance after deductible	$15	No Charge after deductible	30% Coinsurance after deductible	$30
Basic Dental Care - Child	20% Coinsurance after deductible	40% Coinsurance after deductible	$15 Copay and 20% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible	$30 Copay and 40% Coinsurance after deductible
Orthodontia - Child	50% Coinsurance after deductible	50% Coinsurance after deductible	50%	50% Coinsurance after deductible	50% Coinsurance after deductible	50%
Major Dental Care - Child	50% Coinsurance after deductible	50% Coinsurance after deductible	$15 Copay and 50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	$30 Copay and 50% Coinsurance after deductible
Routine Dental Services - Adult	No Charge after deductible	50% Coinsurance after deductible	$15	No Charge after deductible	50% Coinsurance after deductible	$30
Basic Dental Care - Adult	20% Coinsurance after deductible	60% Coinsurance after deductible	$15 Copay and 20% Coinsurance after deductible	50% Coinsurance after deductible	75% Coinsurance after deductible	$30 Copay and 40% Coinsurance after deductible
Orthodontia - Adult	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Major Dental Care - Adult	50% Coinsurance after deductible	75% Coinsurance after deductible	$15 Copay and 50% Coinsurance after deductible	70% Coinsurance after deductible	85% Coinsurance after deductible	$30 Copay and 50% Coinsurance after deductible

Plan details are contained in the plan documents linked on this plan compare, please consult these for full benefit explanations and limitations